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NEWSLETTER



Epidemiology Resource Center
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Outbreak Summary 2000: The Year of the Norwalks

The year 2000 saw new laboratory technology available to identify disease agents and the most reported outbreaks in the last decade, with Norwalk-like viruses leading the list.

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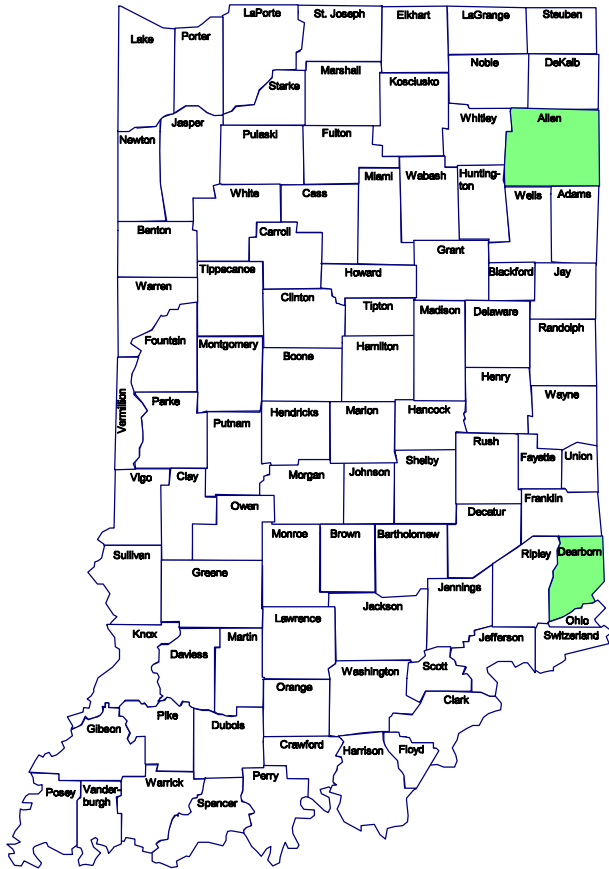
The main objective of any communicable disease outbreak investigation is to identify the infectious agent and the causative factors in order to control the outbreak and prevent further disease transmission. Thorough investigations can also monitor emerging trends and provide a knowledge base to prevent similar occurrences in the future. Therefore, outbreaks or clusters of unusual disease incidence are reportable to the Indiana State Department of Health (ISDH) [IAC 410 1-2.3]. Outbreak investigations should be a collaborative effort between the local health departments and the ISDH. It is the local health department's responsibility to notify the ISDH of the outbreak and to perform the majority of investigative procedures, while the ISDH role is mainly coordination and consultation. In large or complex outbreak situations, the ISDH may provide direct or on-site assistance.

This narrative describes only those outbreak investigations in which the ISDH Communicable Disease Program (CDP) participated. The CDP investigated a total of 32 outbreaks in 2000 (Table 1), an increase of 146% over 1999. Two of these outbreaks were respiratory, and 30 were gastrointestinal. Of the gastrointestinal outbreaks, 12 were foodborne, 12 were spread by person-to-person contact, and 6 outbreaks did not have a conclusive transmission route. No waterborne outbreaks were reported in 2000. The Food Protection Program and the Long Term Care Program, in addition to lending valuable expertise and experience during outbreak investigations, also investigate a substantial number of food-related complaints and other clusters of illness for which the CDP never becomes involved.

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Respiratory

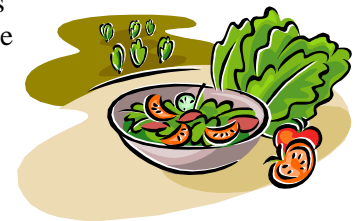


Two pertussis outbreaks occurred in 2000. From April through August, 27 cases were reported in Allen County. Fifty-five percent of the cases were 10 years of age or older, with six cases between 10-19 years of age, and nine others 20 years or older. The first cough onset occurred on April 10, with the last cough onset beginning August 20. Although no common link was apparent for all cases, eleven cases occurred in four different families, three other cases were linked by common contact, and two others occurred in the same daycare center. Four of the cases were hospitalized for an average of 6.5 days. Control measures included notification of physicians in Allen County, letters to parents with children in the daycare centers and schools involved, a locally issued press release, and the recommendation for erythromycin prophylaxis for all attendees and staff at the affected daycare center.

Nine cases of pertussis occurred in Dearborn County during October and November. Eight of the cases were among students attending either the middle or high school in the same school district. The age of these eight cases ranged from 11-16 years. The ninth case was an eight year-old elementary school student in a different school district. Six of the nine cases were culture confirmed as *Bordetella pertussis*. Control measures included sending informational packets to doctors in Dearborn County, letters to parents in the affected schools, and a locally issued press release.

Foodborne/Gastrointestinal

Thirteen confirmed and six suspected outbreaks of Norwalk-like virus occurred in the state in the year 2000. Settings included restaurants, universities and schools, developmental institutions, long term care facilities, churches, catered events, and homes. Seven of these were foodborne, eight were attributed to person-to-person contact, and four did not have a conclusive route of transmission. Foodborne viral outbreaks usually occur when an infected person handles raw foods (salads, vegetables, etc.) or ready-to-eat foods (sliced luncheon meats, rolls, etc.) without thoroughly washing hands after using the restroom. Due to the extremely infectious nature of viral agents, they can also easily be transmitted from person to person via contaminated hands or surfaces. In most cases, there was a background of illness in food handlers or contact with others ill prior to the outbreak. In July, the ISDH laboratories adopted testing methods to confirm viral outbreaks for the first time, allowing more rapid identification and response to outbreaks that were previously not identified.



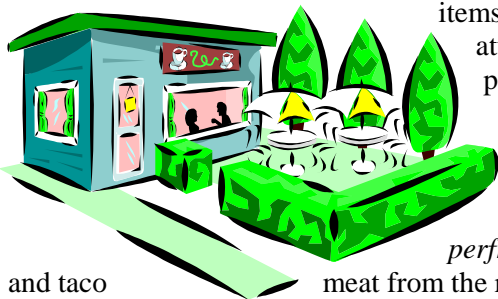
Four outbreaks of shigella occurred in 2000. The causative agent for all of these was confirmed as *Shigella sonnei*. The Marion County Health Department identified over 1,200 cases, particularly in children attending daycare centers and schools and their contacts. Beginning in January and peaking in June, the outbreak had greatly diminished by the end of the year, but had not completely resolved. During June and July, an outbreak occurred at a Fort Wayne daycare center. Cases included at least 32 children and 5 staff members. In July and August, an Elkhart daycare center experienced an outbreak, with at least ten children becoming ill. At least nine students and staff at a Mooresville elementary school developed shigellosis during September and October. *Shigella* can be transmitted through both foodborne and person-to-person routes, however, all of these outbreaks were attributed to person-to-person transmission.

In March, at least 23 people became ill with gastroenteritis at a local elementary school in Marshall County. Statistical analysis revealed that pork sausage served at the school lunch on March 21 was the only food vehicle significantly associated with illness. No food or stool samples were available for testing. However, the clinical syndrome was most compatible with *Salmonella*. Food poisoning due to this agent is usually attributed to inadequate cooking, particularly of poultry and eggs, temperature abuse, and cross-contamination of foods. Several instances of temperature abuse of the sausage were noted. No food workers were ill prior to the outbreak, and no evidence of mishandling was noted, reducing the likelihood of a viral cause.

Several cases of gastrointestinal infection were reported among residents of a mobile home park in Hendricks County in July. The only common exposure was living in the mobile home park. Most cases reported intermittent illness, some of which had been ongoing for over a year. Many cases indicated that they had experienced plumbing problems or had been exposed to contaminated water within the park prior to illness. The exact cause of illness and route of transmission were not determined. Seventeen residents submitted stool specimens: one tested positive for *Campylobacter*, and two tested positive for *Blastocystis hominis*. All others tested negative for enteric bacteria and parasites. The Indiana Department of Environmental Management (IDEM) collected water samples from several sites throughout the park. All tested negative for fecal coliforms; however, some tested positive for total coliforms. This can result from environmental contamination. IDEM noted that the park's water system was deteriorating, and provided alternate water sources to residents. Eventually a temporary water line to Indianapolis municipal water was installed, with plans underway to obtain a permit for permanent municipal water line connection and to redesign the infrastructure.



At least nine patrons became ill with gastroenteritis after eating lunch at a local restaurant in Monroe County on July 24. One patron tested positive for *Clostridium perfringens*. Three samples of refried beans tested positive for *Bacillus cereus*. One sample also had a high aerobic plate count, additional evidence of possible temperature abuse or mishandling. Restaurant inspections revealed inadequate cooling and holding temperatures of food items. Food poisoning from both *C. perfringens* and *B. cereus* is usually attributed to inadequate heating, cooling, and reheating of foods, particularly of meats, stews, gravies, and other thick, dense foods.



and taco meat from the restaurant also tested positive for *C. perfringens*. One sample of cooked shredded beef also had a high aerobic plate count, additional evidence of possible temperature abuse or mishandling. Restaurant inspections revealed several instances of temperature abuse and improper cooling of food items.

In July, an outbreak of *Clostridium perfringens* was reported in Monroe County. Ten cases were identified, all of who had eaten dinner at a local restaurant on July 26. One case tested positive for *C. perfringens*. Food samples, including a leftover taco from one dinner patron



Several inmates became ill with gastroenteritis after attending a cookout at Madison Correctional Facility on July 30. No food vehicle was identified, and no food samples were available for testing. However, the clinical syndrome was most compatible with *Staphylococcus aureus*. Staphylococcal food poisoning is usually attributed to time and temperature abuse. Improper cooling and holding temperatures were noted during a review of food preparation practices.

Thirteen culture-confirmed cases of *Salmonella berta* were identified in Montgomery County from September 2 to September 26. First thought to have occurred at Wabash College, this outbreak actually involved the larger community of Crawfordsville. The exact food source or vehicle could not be conclusively identified, however, seven of the thirteen cases reported eating at a particular local restaurant. Several violations were noted during restaurant inspection that may have contributed to possible food contamination. Food poisoning due to this agent is usually attributed to inadequate cooking, particularly of poultry and eggs, temperature abuse, and cross-contamination of foods.

In October, an outbreak of *E. coli* O157:H7 was reported in Lake County. Six culture-confirmed cases were identified between October 17-23. At least five of these cases reported eating at one Schererville restaurant prior to illness. No other exposure common to all cases was identified. Although no case-control study was conducted to identify a specific food vehicle, all cases reported eating salad. No food employees tested positive for *E. coli*. Food poisoning from this agent is usually attributed to consumption of soil-contaminated produce, inadequate cooking of meat, and consumption of unpasteurized milk or juice. *E. coli* O157: H7 is also easily transmitted from person to person, and one case may have acquired infection via this route.

Based on our experiences in disease investigation, the Communicable Disease Division and Food Protection Program make the following recommendations to local health departments for efficient and scientifically sound disease investigations:

- ▶ ***Ensure that everyone involved in the process is working together.*** This may involve initial and even daily meetings among environmental and nursing staffs.
- ▶ ***Maintain supplies for outbreak investigations.*** Inventory supplies to make sure you are equipped to investigate outbreaks. Containers for collecting stool samples specific for bacterial and viral pathogens (7A) should be readily available. Be sure to check the expiration dates on the containers. New containers can be ordered or expired ones replaced by calling the ISDH Containers Section at (317) 233-8104.
- ▶ ***If an outbreak is suspected, contact ISDH as soon as possible.*** Gather basic information about the outbreak beforehand. This includes:
 - Type of event, location, date, number of meal(s) served and time of meal(s)
 - Source of food served (caterer, home, etc.) and contact person for the source
 - Number of known ill persons
 - Range and times of illness onset
 - Main symptoms
 - Contact person for ill persons and phone number, if possible
 - Menu of all food and beverage items served
 - Availability of clinical and food samples

SUMMARY OF DISEASE OUTBREAKS INVESTIGATED BY ISDH COMMUNICABLE DISEASE DIVISION

INDIANA, 2000

| Month | County | Site | Description | Organism ¹ | Most probable source | Local Participation | Comments ² |
|---------|------------|--------------------------|---|--|----------------------|------------------------|----------------------------|
| January | Marion | Daycare Centers, Schools | Gastroenteritis 1,240 cases ³ | <i>Shigella sonnei</i> | Infected child | Marion CHD | Cases culture confirmed |
| January | St. Joseph | Restaurant | Gastroenteritis 9 cases | --- | Unknown | St. Joseph CHD | Probably viral |
| March | Huntington | College | Gastroenteritis 34 cases | Norwalk-like virus | Unknown | Huntington CHD | 4 cases confirmed |
| March | Marshall | School | Gastroenteritis 23 cases | --- | Sausage | Marshall CHD | Probably <i>Salmonella</i> |
| March | Lake | Developmental Center | Gastroenteritis 6 cases | Norwalk-like virus | Infected employee | Lake CHD | 1 case confirmed |
| April | Cass | Girls' Home | Gastroenteritis 6 cases | Norwalk-like virus | Unknown | Cass CHD | 1 case confirmed |
| April | Allen | Community | Lower resp. infection 27 cases | <i>Bordetella pertussis</i> | Infected case | Allen CHD | 1 case culture confirmed |
| April | Hamilton | Developmental Center | Gastroenteritis 6 cases | Unknown | Unknown | Hamilton CHD | Probably viral |
| April | LaPorte | School | Gastroenteritis 25 cases | <i>Norwalk-like virus</i> Snow Mountain agent | Unknown | LaPorte CHD | 2 cases confirmed |
| May | Porter | Church | Gastroenteritis 16 cases | Unknown | Unknown | Porter CHD Lake CHD | Probably viral |
| May | Marion | Hotel | Gastroenteritis 34 cases | Unknown | Unknown | Marion CHD | Probably viral |
| June | Allen | Daycare Center | Gastroenteritis 44 cases | <i>Shigella sonnei</i> | Infected child | Allen CHD | 44 cases confirmed |
| June | Allen | Assisted Living Facility | Gastroenteritis 25 cases | Norwalk-like virus | Unknown | Allen CHD | 8 cases confirmed |

| Month | County | Site | Description | Organism ¹ | Most probable source | Local Participation | Comments ² |
|-----------|------------|--------------------------|----------------------------------|--|----------------------|------------------------------|----------------------------|
| July | Elkhart | Daycare Center | Gastroenteritis 10 cases | <i>Shigella sonnei</i> | Infected child | Elkhart CHD | 10 cases confirmed |
| July | Hendricks | Mobile Home Park | Gastroenteritis 39 cases | Unknown | Unknown | Hendricks CHD | Inconclusive |
| July | Elkhart | Assisted Living Facility | Gastroenteritis 18 cases | Norwalk-like virus | Unknown | Elkhart CHD | 1 case confirmed |
| July | Monroe | Restaurant | Gastroenteritis 9 cases | <i>Clostridium perfringens</i> <i>Bacillus cereus</i> | Refried beans | Monroe CHD | Multiple etiologies |
| July | DeKalb | Nursing Home | Gastroenteritis 14 cases | Norwalk-like virus | Unknown | DeKalb CHD | 3 cases confirmed |
| July | Monroe | Restaurant | Gastroenteritis 10 cases | <i>Clostridium perfringens</i> | Refried beans | Monroe CHD | 1 case confirmed |
| July | Jefferson | Correctional Facility | Gastroenteritis 4 cases | Unknown | Unknown | Jefferson CHD | Probably <i>S. aureus</i> |
| September | Montgomery | Community | Gastroenteritis 13 cases | <i>Salmonella berta</i> | Unknown | Montgomery CHD Wabash CHD | 13 cases PFGE identical |
| September | Morgan | School | Gastroenteritis 13 cases | <i>Shigella sonnei</i> | Unknown | Morgan CHD | 11 cases confirmed |
| October | Dearborn | School | Lower resp. infection 9 cases | <i>Bordetella pertussis</i> | Unknown | Dearborn CHD | 6 cases confirmed |
| October | Lake | Restaurant | Gastroenteritis 6 cases | <i>E. coli O157:H7</i> | Salad | Lake CHD | 6 cases PFGE identical |
| November | Lake | Nursing Home | Gastroenteritis 20 cases | Norwalk-like virus | Unknown | Allen CHD | 3 cases confirmed |
| November | Allen | Nursing Home | Gastroenteritis 24 cases | Norwalk-like virus | Unknown | Allen CHD | 1 case confirmed |
| November | Marion | Nursing Home | Gastroenteritis 28 cases | Unknown | Unknown | Marion CHD | Probably viral |

| Month | County | Site | Description | Organism ¹ | Most probable source | Local Participation | Comments ² |
|----------|---------|-------------------|-----------------------------|-----------------------|----------------------|--|-----------------------|
| November | Shelby | Restaurant | Gastroenteritis 77 cases | Norwalk-like virus | Possibly coffee | Shelby CHD Brown CHD Hamilton CHD Hancock CHD Marion CHD Tippecanoe CHD | 1 case confirmed |
| December | Madison | College | Gastroenteritis 96 cases | Unknown | Unknown | Madison CHD | Probably viral |
| December | Henry | Private residence | Gastroenteritis 14 cases | Norwalk-like virus | Unknown | Henry CHD | 1 case confirmed |
| December | Marion | Nursing Home | Gastroenteritis 38 cases | Norwalk-like virus | Unknown | Marion CHD | 7 cases confirmed |

1. Organisms culture-confirmed from stool samples, foods, other environmental sources, or determined by serologic testing.
 2. Assessment of likely etiology based on incubation period, distribution of cases, and spectrum of symptoms shown.
 3. Cases reported to ISDH as of January 31, 2001.
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Contact Investigations in Tuberculosis Control

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**March 24, 2001 is
World TB Day.**

This commemorates
Robert Koch's

discovery of *Mycobacterium*

tuberculosis, the organism that causes tuberculosis (TB). Since that time, great strides have been made in the treatment of the disease, and advances have been made in the quest for its elimination. Reported cases are at an all-time low in the United States and in Indiana.

Cases continue to decline because of the intense focus on the most important priority in TB control, which is the identification and prompt treatment of active cases. The second most important priority in TB control is the timely performance of a contact investigation. This is an essential element of TB control that is not well understood by the public.

A contact investigation is conducted to identify and examine persons who were recently exposed to a case of active pulmonary or laryngeal tuberculosis and who:

- ▶ Have TB disease, so that they can be given treatment and stop further transmission.
- ▶ Have latent TB infection (LTBI), so that they can be given treatment to prevent the development of active disease.
- ▶ Are at high risk of developing TB disease and may need treatment for LTBI until TB infection is ruled out.

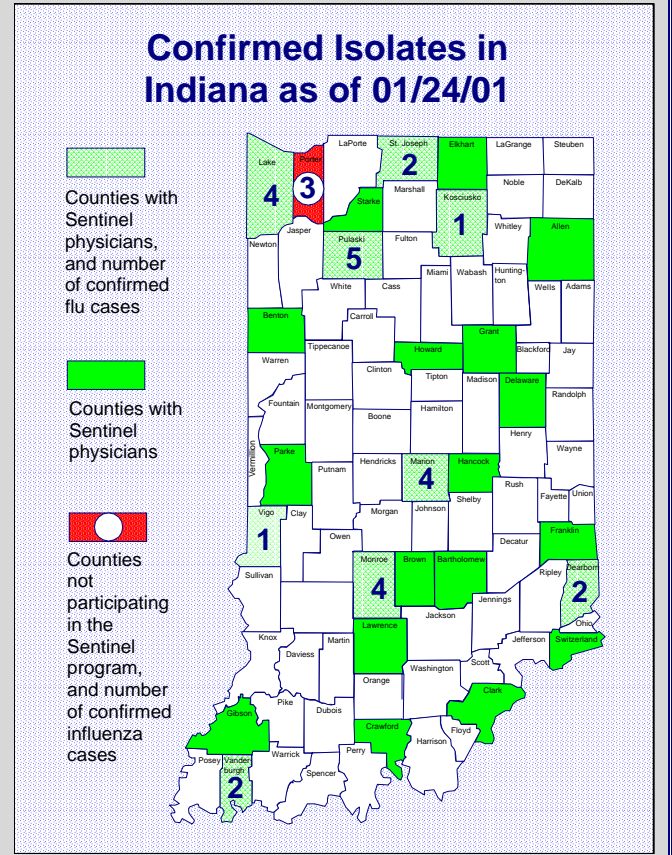
The likelihood that a person with pulmonary or laryngeal TB is infectious depends on several factors. The presence of acid-fast bacilli in the sputum is the most important indicator of infectiousness. Other indicators that increase the likelihood of the patient being infectious are a cough, hoarseness, a chest x-ray that shows the presence of a cavity in the lung, or that the patient is either not receiving treatment or has only recently started treatment.

Flu Is Here

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The Indiana sentinel influenza sites have reported an increase of influenza illness. According to the CDC weekly influenza report for the week ending 01/27/01, sentinels in the following counties have reported percentages of total patients with influenza-like illness (ILI) above 5%: Pulaski County (34%), Switzerland County (13%), St. Joseph County (11%), Vanderburgh County (10%), Lake County (9.5%), and Monroe County (5%). This is markedly above the normal percentage (1-3%) of ILI observed this season so far, but the present influenza activity in Indiana is still considered sporadic.

In addition, the number of patient specimens submitted to the ISDH Laboratories has increased. Twenty-eight isolates have confirmed positive, with 26 typed as influenza A. Ten of type A isolates have been subtyped as New Caledonia strain, one of the strains included in the current vaccine. Two of the 28 isolates have been typed as influenza B. Figure 1 shows the county distribution of confirmed cases.





Contact investigations are conducted using a technique known as the “concentric circle” approach. This process involves testing the closest contacts first and then expanding the screening if there is evidence of transmission among the closest contacts. The emphasis is on those who spend significant time in close contact with the active case, such as in the household or residence, work, school, and places of leisure or social activities.



Evaluation of contacts consists of administering and reading a tuberculin skin test. If the test is negative, a second test is performed 10 weeks after contact with the active case is broken, because it may take that long after exposure for a positive TB skin test to develop. If either of these two skin tests are positive (≥ 5 mm of induration), a chest x-ray is given to rule out active disease, and the person is questioned about TB symptoms. Further testing may be indicated if there are symptoms of TB or if the chest x-ray is abnormal. Tests would include collecting samples of sputum or other fluids or tissues to check for acid-fast bacilli. The contacts are then placed on treatment for either LTBI or active disease as appropriate.

Identifying and evaluating close contacts is important because the rate of TB disease is approximately 75 times higher in close contacts than in the general population. On the average, 20 percent of close contacts of infectious TB cases become infected. It has been estimated that each person with active pulmonary TB will infect ten people before they are diagnosed and treated.

Incomplete or delayed identification, evaluation, and follow-up of contacts can occur because of delays in reporting the index case, inadequate local health department staffing, difficulty in tracking contacts, the occasional unwillingness of the index case to identify contacts, and failure of the investigators to use the concentric circle approach.

Barriers to contact investigations that are frequently encountered:

- **Lack of local health department personnel to conduct an adequate contact investigation**

Some health departments have only one nurse, who is also responsible for other program areas as well as TB. Investigators may fail to re-interview patients for additional contacts not identified during the initial interview. Inconsistent use of the concentric circle approach leads to inappropriate use of time and resources, a lack of focus, and inappropriate skin testing of contacts (both too few and too many). Sometimes there may be confusion over jurisdictional responsibility when contact tracing involves people located in different counties.



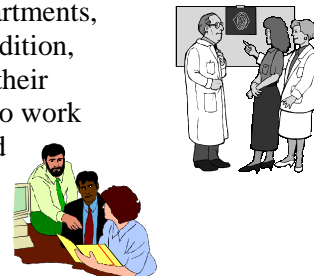
- **Communication problems**

Timely and complete communication between health department and facility personnel is an obstacle in conducting contact investigations in jails, prisons, hospitals, factories, and other facilities. Because of a lack of understanding of how to conduct a contact investigation, as well as frequent political pressure, the entire population of the facility may be skin tested without regard to using the concentric circle approach.

Problems also arise between health department staff and the patients, who will sometimes be reluctant to identify their contacts. This is especially true when illegal activities or illicit social contacts are involved. Racial and ethnic minorities are sometimes reluctant to trust someone outside of their group. Contacts are often missed as a result. Finally, persons who are identified as close contacts will not always cooperate by allowing themselves to be skin-tested or receive a chest x-ray if necessary.

In conclusion, there are several activities that must take place for contact investigations to be effective. Contact investigations must be initiated promptly. Local health departments must ensure that contact investigations are initiated as soon as TB is diagnosed or strongly suspected in a patient. The interview with the patient should take place no more than 3 working days after the case is reported. Close contacts should be examined within 7 working days of the index case being diagnosed or suspected of having TB. The new Communicable Disease Reporting Rule, 410 IAC 1-2.3 (www.state.in.us/isdh/publications/comm_dis_rule.pdf), discusses the local health departments' responsibilities regarding contact investigations. The index case's social circles also need to be considered along with household and workplace contacts.

Effective communication must be achieved and maintained between local health departments, health facilities, physicians, and community social organizations and networks. In addition, effective communication skills must be practiced when dealing with the patients and their contacts in order to ensure their cooperation. The local health departments should also work closely with their medical community, mental health and substance abuse centers, and homeless shelters. During the investigation, the health departments typically provide TB education for the TB patient's employer.



References:

1. Centers for Disease Control and Prevention. *Core Curriculum on Tuberculosis, 4th Edition, 2000.*
2. Institute of Medicine. *Ending Neglect: The Elimination of Tuberculosis in the United States.* 2000.
3. Friedman, Lloyd N. *Tuberculosis: Current Concepts and Treatment.* Boca Raton: CRC Press. 1994.
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5. Centers for Disease Control and Prevention. *Self-Study Modules on Tuberculosis*, March 1995.

Impact of Obesity in Indiana

Judy Rose, R.D., C.D.
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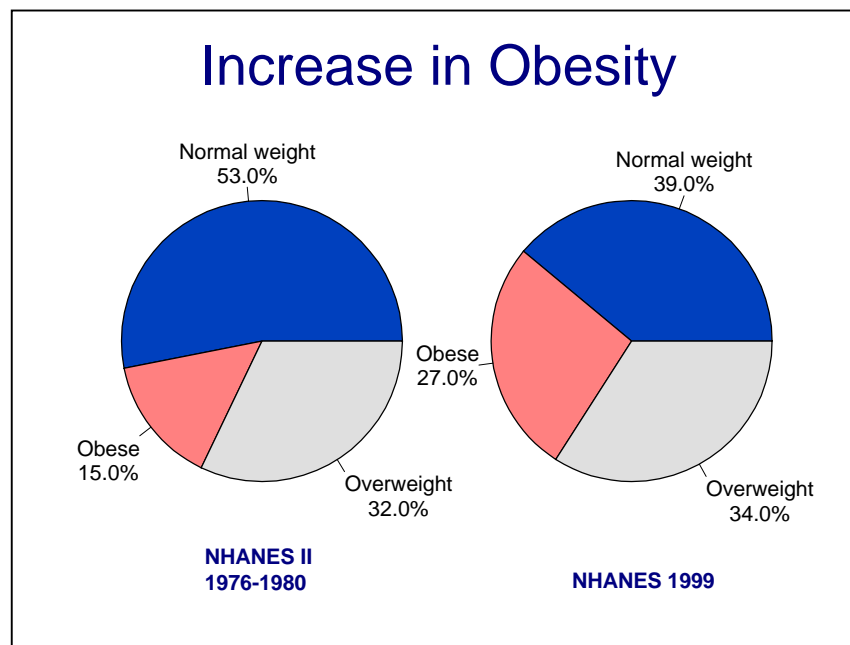
The impact of obesity on public health is well documented. Even when made aware of the costs, both personal and fiscal, the American public fails to see obesity as a public health problem. Americans are accustomed to applying a medical model as the solution to health problems. Unfortunately, the medical model for treatment of obesity has proven ineffective and at the same time, prohibitively expensive.

Prevention, rather than medical treatment, is a primary function of public health. Prevention has played a major role in reducing the threat of food- and water-borne illnesses that once took many lives annually. Immunizations have greatly reduced the threat of many of the communicable diseases that once plagued the population. The simple addition of iodine to table salt and B vitamins to flour has reduced to mere memory diseases like simple goiter, pellagra, and beriberi. Unfortunately, prevention of obesity and its consequent chronic diseases is not so simple.

Prevention of many of the nutrition-related diseases, which are now part of our history, involved a simple act, often passive, to achieve results. Obesity cannot be prevented by simply adding an essential nutrient to the food supply or by improving sanitation. A small percentage of people are blessed with a genetic makeup, which does not predispose them to weight gain. Obesity is not the result of a single causative factor, but the result of a lifetime of unhealthy habits and behaviors. Reversing lifetime habits is a challenge, which although not impossible, can be more than most people can achieve.

The American public has experienced a dramatic increase in obesity since the National Health and Nutrition Examination Survey (NHANES II) conducted between 1976-1980. In comparing data from NHANES II and NHANES 1999 (Figure 1), we see that the percentage of overweight people has changed little, but the percentage of obese people has gone from 15% to 27% - almost double! The category that has decreased is the percentage of people of normal weight.

Figure 1.



The habits and behaviors that lead to obesity are formed early in life and have multiple causes. Lifestyles have changed dramatically over the last century. Work and home environments seldom require the same amount of physical activity to accomplish daily tasks. During this same period when food and energy requirements have decreased, availability of all foods has increased. There has been a proliferation of low nutrient density, high calorie, high fat foods developed and marketed to the public.

Most households do not have a full-time homemaker. This decreases the amount of time dedicated to meal selection and preparation. Foods are chosen, not on the basis of nutrition content, but for convenience and taste preference. Most foods that fit into this category are high in calories and fat, but low in nutrient content. This is one of the factors that set the stage for obesity.

Another contributing factor is the trend toward a more sedentary lifestyle. Children once walked 1-2 miles to and from school, but they now ride a bus or are driven. After school, most children will occupy their time until parents come home with video games, Internet activity, television, or videotapes. These activities require less energy than vigorous play, yet they are likely to snack on high fat, high calorie foods while sitting.

Adults are no less likely to follow a similar routine, especially if this became a habit during their youth. Time limitations affect not only food choices, but physical activity as well. Busy schedules and time obligations are the reasons given by most adults for not spending the 20 minutes a day recommended as the minimum of moderate to vigorous physical activity to maintain health. To put this in perspective, 20 minutes out of the total of 1440 minutes in a 24-hour period is only 1/72, or 1.4%, of the day.

If the situation looks grim - it is. In a recent report by the American Obesity Association on *Costs of Obesity*, the direct costs of all treatments for obese adults was estimated to be \$238 billion in 1999. This study also found that approximately 75% of the direct costs were attributed to five diseases: 1) type 2 diabetes, 2) heart disease, 3) stroke, 4) hypertension, and 5) arthritis. These costs address neither the personal costs nor the quality of life issue. The question is basically whether to simply treat obesity-related illnesses or try to prevent obesity and its consequences.

At a recent meeting of the American Obesity Association, Dr. William Dietz, director of the Division of Nutrition and Physical Activity at the Centers for Disease Control and Prevention, referred to obesity as an epidemic. Dr. Dietz, a pediatrician, referred to the Healthy People 2010 weight objectives, and said "There's no implementation plan" to realize these goals. He added, "I don't think we've ever had such a rapid onset of an epidemic that has affected so many people." He said that while past federal programs made great contributions to health, today's congressional and financial support for obesity, the most pressing nutritional concern, has been minimal, despite a surge in willingness among agencies such as the Department of Health and Human Services to address the nation's obesity problem.

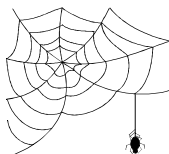


Many factors contribute to the development of obesity. In order to reverse the condition, multiple changes must be made. Some involve intense lifestyle change for the individual, which require readiness for change and dedication to maintaining those changes. Some factors affecting obesity can be improved by changing policy and the environment. School and work environments can offer and market healthful foods or fall into the trap of promoting items that are high in fat, sugar and calories. Policy can establish criteria for healthy foods for shared events such as birthday parties, instead of accepting the traditional cakes and pastries. Most children (and some adults) are unable to make informed decisions on food choices when less desirable foods are constantly available.

Few jobs offer the opportunity for physical activity during the workday. Sitting at a desk all day is truly a health hazard. It is hard to balance sleeping and sedentary time with enough physical activity unless every opportunity for activity during the workday is maximized. Take the stairs instead of the elevator. Even if there is no reason to take the stairs other than for the exercise, it can make a significant contribution to health. Many people can choose to walk to work from a distant parking lot rather than catch a ride to the door.



Surgeon General David Satcher recently launched a national action plan for reducing the prevalence of overweight and obesity in the United States. He plans to establish strategies and set priorities in order to successfully implement obesity prevention efforts that focus on the family and community, schools, work sites, the health care delivery system, and the media. Indiana stands poised to participate with Dr. Satcher in his quest to reverse the obesity epidemic. (Image obtained by permission from the Surgeon General's Office www.surgeongeneral.gov.)



Wonderful Wide Web Sites

ISDH Data Reports Available

The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:

<http://www.state.in.us/isdh/> (under Data and Statistics)

| | |
|--|--|
| Indiana Cancer Incidence Report (1990, 95) | Indiana Mortality Report (1995, 97) |
| Indiana Cancer Mortality Report (1990-94, 1992-96) | Indiana Natality Report (1995, 96, 97) |
| Indiana Health Behavior Risk Factors (1995-96, 97, 98) | Indiana Natality/Induced Termination of Pregnancy/Marriage Report (1998) |
| Indiana Hospital Consumer Guide (1996) | Indiana Report of Diseases of Public Health Interest (1997, 98, 99) |
| Indiana Marriage Report (1995, 96, 97) | |

The following site allows access to the web page for any state health department in the United States:

<http://www.polsci.wvu.edu/grad/klase/STATEHEALTH/sthlth.html>

HIV Disease Summary

Information as of January 2001 (population 5,840,528)

HIV - without AIDS to date:

| | | | |
|-------|---|--------------------|----------------------------------|
| 304 | New cases from February 2000 thru January 2001 | 12-month incidence | 5.21 cases/100,000 |
| 3,293 | Total HIV-positive, without AIDS on January 31, 2001 ¹ | Point prevalence | 56.39 cases/100,000 ¹ |

AIDS cases to date:

| | | | |
|-------|---|--------------------|----------------------------------|
| 347 | New AIDS cases from February 2000 thru January 2001 | 12-month incidence | 5.94 cases/100,000 |
| 2,705 | Total AIDS cases on January 31, 2001 ¹ | Point prevalence | 46.32 cases/100,000 ¹ |
| 6,114 | Total AIDS cases, cumulative (alive and dead) | | |

¹Counting only cases alive in January 2001

REPORTED CASES of selected notifiable diseases

| Disease | Cases Reported in January MMWR Weeks 1-4 | |
|---|---|-------|
| | 2000 | 2001 |
| Campylobacteriosis | 9 | 7 |
| Chlamydia | 767 | 1,003 |
| Invasive Drug Resistant <i>S. pneumoniae</i> (DRSP) | 6 | 3 |
| <i>E. coli</i> O157:H7 | 1 | 0 |
| Hepatitis A | 2 | 0 |
| Hepatitis B | 1 | 0 |
| Gonorrhea | 424 | 459 |
| Legionellosis | 0 | 21 |
| Lyme Disease | 0 | 0 |
| Meningococcal, invasive | 4 | 0 |
| Pertussis | 0 | 0 |
| Rocky Mountain Spotted Fever | 0 | 0 |
| Salmonellosis | 8 | 7 |
| Shigellosis | 11 | 9 |
| Primary and Secondary Syphilis | 31 | 5 |
| Tuberculosis | 9 | 9 |
| Animal Rabies | 0 | 0 |

**For information on reporting of communicable diseases in Indiana,
call the ISDH Communicable Disease Division at (317) 233-7665.**

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